SPOKANE pediatrics
A CHAS Health Clinic

Spokane Pediatrics
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please email records to spokanepediatrics@protonmail.com

Patient's Name: _____ **Date of Birth:** _____

Previous Physician: _____ **Phone:** _____

Address and Fax: _____

I request and authorize release of information of the patient named above to:

Spokane Pediatrics
315 W. 9th AVE STE 200
Spokane, WA 99204

This request and authorization apply to:

- ☑ Progress Notes (last 2 years)
- ☑ NB Discharge Summary
- ☑ Diagnostic Reports (lab, x-ray, EKG, last 2 yrs.)
- ☑ Specific Dates, Treatments, condition
- ☑ History and Physical
- ☑ Immunizations
- ☑ Growth Charts
- ☐ Other

☐ I authorize the release of my STD results, HIV/Aids testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. *

☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person (s) listed above. *

I hereby consent to the release of the above information. I understand that such information cannot be released without my informed consent. I understand that this authorization expires 90 days after date signed. I understand that I may revoke this authorization at any time by notifying Spokane Pediatrics in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

YOUR SIGNATURE BELOW CONFIRMS THAT YOU UNDERSTAND AND AGREE TO THE TERMS OUTLINED.

_____ _____ _____
Parent/Guardian Signature Relationship to Patient Date

* If the patient is a minor but is authorized to consent to health care without parental consent under federal and state law (age 13 and above for drug and alcohol information; age 14 and above sexually transmitted disease information, including HIV/AIDS: and age 13 for mental health information only the patient shall sign this authorization form.